

Anal Sphincter Lacerations Underreported at Discharge

BY JANE SALODOF MACNEIL
Southwest Bureau

SCOTTSDALE, ARIZ. — Anal sphincter laceration during childbirth is not accurately coded in many hospital discharge records and may be underestimated as a result.

The Pelvic Floor Disorders Network found mistakes in about one-quarter of 392 hospital discharge records from nine institutions participating in one of its trials, according to a poster presented at the annual meeting of the Central Association of Obstetricians and Gynecologists.

Dr. Linda Brubaker reported an average coding error rate of 24% across the nine centers. Just one institution was free of mistakes. The three highest error rates were 62%, 48.6%, and 27.2%.



'Improved coding may provide an opportunity to improve patient care.'

DR. BRUBAKER

The network warned that the result of this type of coding error could be a substantial underassessment of delivery-associated anal sphincter laceration as a maternal morbidity. It recommended against using hospital discharge coding as a source of data when making estimates.

The discrepancies could have significant implications for quality assurance and research initiatives. Dr. Brubaker told this newspaper subsequently that both the Joint Commission on Accreditation of Health Care Organizations and the Annual Public Health Report will be using the incidence of obstetric third- and fourth-degree lacerations as indicators of care quality.

The bottom line, Dr. Brubaker concluded, is that these lacerations have not received the attention they deserve. "Improved coding [and the use of these events as quality indicators] may provide an opportunity to improve patient care and identify women who may benefit from postdelivery pelvic floor assessment," she said.

Sponsored by the National Institutes of Health, the network recently opened a Web site at www.pfdn.org. The anal sphincter laceration study was a subanalysis of data from the network's childbirth and pelvic symptoms (CAPS) trial, which is supported by the National Institute of Child Health and Human Development.

The trial is comparing women with anal sphincter laceration at vaginal delivery with women who underwent cesarean delivery without labor and women who delivered vaginally without anal sphincter laceration in the trial. ■

Mifepristone Tied to Increased Bleeding In Progesterone-Releasing IUD

MONTREAL — Contrary to its effect with other progesterone-only contraceptives, mifepristone increases breakthrough bleeding in patients using the levonorgestrel intrauterine system, according to a new study.

"Mifepristone cannot be recommended as a therapy for breakthrough bleeding in new users of the LNG-IUS," reported Dr. Megan Economidis of the Keck School of Medicine at the University of Southern California in Los Angeles.

Mifepristone, an antiprogesterone, has been shown to decrease irregular bleeding in users of progesterone-only implants and injectables. But when given to 20 regularly menstruating women who were new starters of the LNG-IUS, mifepristone actually had the opposite of its usual effect, she said at the joint annual meeting of the American Society for Reproductive Medicine and the Canadian Fertility and Andrology Society.

The women in the study, 18-45 years old, were randomized to receive mifepristone 50 mg or placebo every 2 weeks for six cycles. The treatment was started 2 weeks after LNG-IUS insertion.

Over the six cycles, the median number of days of breakthrough bleeding was 57 in the mifepristone group, compared with 26 in the placebo group; this difference was statistically significant. In addition, when all the subjects' cycles were combined, there were 22 (42%) mifepristone cycles with more than 8 days of breakthrough bleeding vs. 16 (27%) placebo cycles. This difference was not statistically significant.

Endometrial biopsies showed a decrease in endometrial estrogen receptors after mifepristone treatment. This is in contrast to other studies of progesterone implants and injectables, which have shown an increase in estrogen receptors with mifepristone treatment, she said.

—Kate Johnson

Rates of Stress Urinary Incontinence Similar in Nulliparous, Parous Sisters

Vaginal birth does not contribute to the development of stress urinary incontinence later in life, according to Dr. Gunhilde M. Buchsbaum, of the department of ob.gyn at the University of Rochester (N.Y.), and colleagues.

"Contrary to the conventional wisdom that nulliparity protects against stress urinary incontinence, we found similar rates of urinary incontinence in postmenopausal nulliparous women and their parous biological sisters," the investigators reported (*Obstet. Gynecol.* 2005;106:1253-8).

Dr. Buchsbaum's team analyzed a sample of 143 pairs of nulliparous and parous postmenopausal sisters. All of the women answered a questionnaire about symptoms of pelvic floor disorders, and 101 pairs also underwent clinical

evaluation of urinary incontinence and genital prolapse.

The researchers found that 47.6% of nulliparous women and 49.7% of parous women reported urinary incontinence, with no difference in type and severity of urinary incontinence between the groups.

Of interest was the finding that there was "a high concordance in continence status ... within biological sisters," according to Dr. Buchsbaum. This finding suggests that there may be a genetic predisposition for urinary incontinence. If that proves to be true, it "would have great implications for the direction of basic research, treatment approaches, risk management, and potential prophylactic interventions."

—Martha Kerr

Pelvic Floor Disorders Don't Require Activity Restrictions

BY SHARON WORCESTER
Southeast Bureau

ATLANTA — Most activity restrictions recommended for preventing the progression or recurrence of pelvic floor disorders are unwarranted, results of a small study suggest.

Several daily activities, such as lifting and exercising, are often restricted in patients with pelvic floor disorders and in those who undergo pelvic floor surgery, because there is concern that the activities can increase intraabdominal pressure and thereby exacerbate the disorder, Dr. Larissa F. Weir explained at the annual meeting of the American Urogynecologic Society.

In fact, of 23 physical activities tested in 30 women who were not undergoing treatment for pelvic floor disorders, most had no greater effect on intraabdominal pressure than unavoidable or typically unrestricted activities had, said Dr. Weir,

who was a medical student at the University of Iowa, Iowa City, at the time of the study, but who is now a first-year resident at the San Antonio Uniformed Services Health Education Consortium.

Lifting technique with higher-weight items did, however, have an effect on intraabdominal pressure, she noted.

Activity restrictions can have a significant impact on daily life, so it is important that they are based on evidence, Dr. Weir said.

These findings lay a foundation for evidence-based revisions of current activity restriction recommendations, but prospective long-term studies of the impact of intraabdominal pressure on pelvic floor function and of the effects of

physical activity on intraabdominal pressure are needed, she added.

Women in the study performed three repetitions of each activity, and intraabdominal pressures were measured using a microtip rectal catheter. The mean peak and net intraabdominal pressures associated with the repetitions were calculated and compared with the baseline values in each patient.

The peak values for activities such as coughing, climbing stairs, and lowering to and rising from the floor, and for exercises such as jumping jacks, abdominal crunches, walking, and jogging on a treadmill were not significantly different from those for rising from a chair. Rising from a chair produced significantly higher abdominal pressures than lifting 8-10 pounds, Dr. Weir said.

The activities that produced the highest peak and net pressures included lifting 20 and 35 pounds off the ground, and forceful coughing; those that produced the lowest peak and net pressures were lifting 8 pounds from a low table, from counter height, and overhead.

As weight increased, lifting technique became more important: Compared with rising from a chair, lifting 8 or 13 pounds from the floor produced less intraabdominal pressure, while lifting 20 pounds from the floor did not. But lifting 20 pounds from counter height did produce less intraabdominal pressure. Lying supine on the ground—an unrestricted activity—produced intraabdominal pressure not significantly different from lifting 35 pounds off a counter. And lifting 35 pounds off a counter produced pressure significantly less than lifting 20 pounds off the ground, she said. ■

Peak values for exercises such as jumping jacks, abdominal crunches, and jogging were not significantly different from those for rising from a chair.